Illinois Workers' Compensation Commission
IWCC Responses to Comments Made During the Public Comment Period
To the Proposed Changes to the Medical Fee Schedule
Released 10/2/08

Evaluation of all comments received by the Agency during the first notice period:

A) A list of all persons or organizations making comments on the proposed rulemaking:

Steve Bennett
Assistant General Counsel
American Insurance Association (AIA)

Mary E. Breeden
Senior Vice President, Managed Care
OSF Healthcare System

Ann Bresnen
Director of Business Development
Midwest Orthopaedic Network

Elena Butkus
Vice President, Finance
Illinois Hospital Association (IHA))

Anne Cole
Administrator
Ingalls Same Day Surgery Center

Mark Mayo
Director
Ambulatory Surgery Center Association of Illinois

Barbara Molloy
President
Molloy Consulting Incorporated

Marti Panikkar
Medical Review Specialist, Risk Management Department
Arkansas Best Corporation

Jay Shattuck
Executive Director, Employment Law Council
Illinois State Chamber of Commerce

B) A list of specific criticisms, suggestions, and comments raised by interested persons and the agency's analysis of each of these criticisms, suggestions and comments.

1) Steve Bennett (Assistant General Counsel, American Insurance Association)

a) Mr. Bennett states that the intent of the 2005 legislation was to lower medical costs while increasing benefits, but there has been an increase in overall costs with little or no decrease in medical costs. He states that the proposed fee schedules are generally consistent with Section 8.2 of the Act but there are two ambiguities in Section 7110.90(h)(7)(F)(iv) (hospital outpatient cost outliers). He states that the first ambiguity is that a cost outlier may be based solely on the amount billed, which rewards hospitals that inflate billing, and it is unclear as to whether there must be a separate finding of extraordinary treatment to qualify as an outlier. He suggests a process that requires a finding of both extraordinary treatment and cost of services. Mr. Bennett states that the second ambiguity is that the outlier language, "is equal to or two times the fee schedule amount," could allow outlier status if the hospital charge is "equal to" the fee schedule amount.

Agency Analysis: Section 8.2(c) of the Act requires the Commission to establish a rule that determines when to make an additional adjustment to the fee schedule for outliers that involve extraordinary treatment. The hospital outpatient surgical facility outlier proposal is similar to the existing hospital inpatient outlier rule that was adopted in 2006. The definition sets a high threshold intended to capture cases involving extraordinary treatment and is supported by the Illinois Hospital Association. Both the Center for Medicare Services (CMS) and private health care plans determine outliers based on a fixed cost threshold because it is too difficult to determine outliers on a case-by-case basis. If the Commission determined outliers on a case-by-case basis, litigation would increase and the certainty intended by the fee schedule would be jeopardized. The most practical way to identify outliers is on a cost basis. Outliers are rare and there is no evidence that hospitals are setting fees to gain outlier status in non-outlier cases. The Commission agrees that the proposed language Section 7110.90(h)(7)(F)(iv) should be clarified and changed the language to read "is at least two times the fee schedule amount". For consistency, the Commission also made the same change to the hospital inpatient outlier language in Section 7110.90(h)(6)(G).

b) Mr. Bennett states that Section 7110.90(h)(7)(F)(ii), which reimburses medical devices that qualify as pass through charges at 65% of charge, is not authorized by Section 8.2 of the Act and leads to inflated charges. He recommends that the carve-out provisions be deleted from the rules or, if retained, provide reimbursement at 100% of the actual costs paid by the hospital, plus about 10%, less rebates, refunds, or other reimbursements received by the hospital from the vendor.

Agency Analysis: Both Sections 8.2 and 16 of the Act gives the Commission broad authority to fix medical fees. The reimbursement of pass-through charges at 65% was extensively debated before it was adopted in 2006. The purpose of setting pass-through charges at 65% of charge was cost containment and the utilization of new and improved technologies that did not exist during the period of historical charge data (August 1, 2002 through August 1, 2004). Like the hospital inpatient schedule, the Commission removed charge data in 8 revenue codes so the new technologies can be reintroduced. The 35% cutback and the removal of the charges from the global reimbursement represent a significant improvement for payers. Any deviation from a charge master amount requires scrutiny by the payer. There is no evidence that hospitals are manipulating their charge masters.

2) Mary E. Breeden (Senior Vice President, Managed Care , OSF Healthcare System

a) Ms. Breeden states that the definition of emergency room visits in Section 4 of the instructions and guidelines should be defined the same as in Section 7D (hospital outpatient surgical facility) as bills containing revenue codes 450-459. She also states that facilities may use code 516 as an alternative to code 456 (urgent care) and requests that the IWCC verify whether emergency room facility services include all urgent care visits with codes 456 and 516 or only visits with revenue code 456.

Agency Analysis: Emergency room is already defined in Section 7110.90(h)(4)(A) of the rules and Section 4 of the guidelines. The Commission does not believe the services in the emergency room schedule should be limited to codes 450 to 459 because the treatment covers more codes than 450 to 459. Code 516 should not be included in the emergency room services because code 516 covers urgent care in a clinic setting and not in an emergency room.

b) Ms. Breeden proposes that language indicating that professional services billed by a hospital using the hospital's tax ID number should be paid at 76% of charge, and professional services billed using their own tax ID number should be subject to the professional services fee schedule be used throughout the instructions and guidelines for consistency purposes. She indicates that if professional services are billed on a UB92/04 they should be identified by revenues codes 960-989.

Agency Analysis: The Commission believes that it adequately addressed how professional services are paid throughout the rules and the instructions and guidelines. Language regarding how professional services are paid appears in Sections 7110.90(h)(7)(C)(iii) (radiology), 7110.90(h)(7)(D)(iii) (pathology and laboratory) and 7110.90(h)7)(F)(vi) (HOSF) of the outpatient schedule. In addition, the Commission added language to address how professional fees are paid in the hospital inpatient schedule in Section 7110.90(h)(6)(H)) and Section 6 of the instructions and guidelines. It is not necessary to refer to revenue codes 960-989 because the general language covers all the revenue codes that might apply.

c) Ms. Breeden suggests that Section 6B of the instructions and guidelines, which requires that the DRG be identified in a manner consistent with CMS Grouper Version 23.0 and 24.0, include examples of version 25 (MS DRG) that can be listed on the claim in Box 78. She states that many facilities converted to the MS DRG methodology as required by Medicare and without examples of version 25 payers may be confused and may not accept the billing.

Agency Analysis: The Commission plans to update the DRG coding system to the new MS DRG coding system by June 30, 2009 (Section 7110.90(h)(6)(B) of the proposed rules initially set a deadline of January 1, 2009 but the Commission changed the deadline to June 30, 2009 because more time is needed to make the conversion). The Commission has posted the CMS cross-walk during the transitional period. The Commission believes that the current language in the guidelines is adequate and placing special emphasis on the V25 grouper could actually lead to confusion because the fee schedule is based on the V24 grouper.

d) Ms. Breeden states that Section 6C of the instructions and guidelines (hospital inpatient DRG as global reimbursement) makes no mention of how to handle inpatient professional fees billed under the hospital's tax ID. Ms. Breeden states the language in Section 6C indicating that the DRG fee schedule amount reflects the maximum medical reimbursement is confusing. She states that the IWCC should include examples about when to apply the fee schedule amount if

total billed charges (minus carve-outs) are less than the schedule. Ms. Breeden states that Section 6D (cost outlier) needs to include mention of hospital professional fees and include these in the cost outlier example.

Agency Analysis: It is universally understood that professional fees are not part of DRG reimbursement. However, the Commission has added language regarding how professional fees are paid in Section 7110.90(h)(6)(H) of the hospital inpatient schedule and Section 6 of the instructions and guidelines for clarification purposes. The Commission made changes to Section 7110.90(h)(6)(A) of the rules to reflect that the DRG is that "maximum fee schedule amount" rather than the "maximum payment amount." The Commission has added payment examples, which include examples of bills with carve-outs and professional fees, to the instructions and guidelines on its website.

e) Ms. Breeden suggests that the Commission clarify professional fees at the beginning of Section 7 of the instructions and guidelines (hospital outpatient) by adding the professional fee clarification language with directions that it applies to all sections that provide instruction on the carve-out revenue codes.

Agency Analysis: The Commission does not believe that it is necessary to provide language regarding professional fees at the beginning of Section 7 because it is carefully addressed in Section 7D.

f) Ms. Breeden states that the radiology CPT code range (320 to 359) should be expanded to include additional revenue code ranges 400 to 409 and 610 to 619 because some CPT codes are normally billed with these additional revenue codes.

Agency Analysis: The Commission acknowledges that revenue codes 320 to 359 may not cover all radiological procedures. Therefore, revenue codes 400 to 409 and 610 to 619 have been added to the Section 7A of the instructions and guidelines and to Section 7110.90(h)(7)(C)(i) of the rules.

g) Ms. Breeden states that the Commission needs to clarify the "lesser of" language in the hospital outpatient radiology, pathology and laboratory, and physical medicine and rehabilitation schedules to identify what prevails if a billed charge is less that the fee schedule amount. She states that it is her interpretation that the billed charge prevails but recommends that examples be used to illustrate the point.

Ms. Breeden recommends that the hospital outpatient schedule be clarified to state that it is based on billed units to ensure that all services are included in the payment calculation. She suggests that bilateral services be clarified. She states that if a CPT is coded with a bilateral modifier, and shows as one unit on the UB92/04 it should be counted as 2 units since 2 tests were performed. Ms. Breeden states that the IWCC needs to address how new codes will be paid.

Agency Analysis: Section 8(a) of the Act and Section 7110.90(d) of the rules provide that the employer pays the lesser of the rate set forth in the schedule or the provider's actual charge unless there is a negotiated rate, in which case the negotiated rate prevails. The Commission changed the proposed language in Section 7110.90(h)7)(C)(i), radiology, Section 7110.90(h)7)(D)(i), pathology and laboratory, and Section 7110.90(h)(7)(E)(i), physical medicine and rehabilitation, from "one level of maximum reimbursement" to the "maximum fee schedule amount" to clarify that the fee schedule amount may not be the amount paid if the

actual charge is less than the fee schedule. The Commission has also added payment examples to the instructions and guidelines.

The Commission changed Section 7110.90(h)(7)(B) to indicate that the radiology, pathology and laboratory and physical medicine and rehabilitation schedules shall be applied to the number of units billed on the UB-04. The Commission believes the instructions and guidelines are clear that a bilateral procedure (modifier 50) is billed as 1 unit and paid at 150%. This reimbursement is based on CMS methodology. The Commission has added payment application examples to the instructions and guidelines to address any confusion or concerns. Regarding new codes, Section 8.2 of the Act provides that the schedules are to be based on historical charge data from August 1, 2002 to August 1, 2004. New codes that did not exist between August 1, 2002 and August 1, 2004 have no historical charge data from which fees can be derived and they therefore default to 76% of charge.

h) Ms. Breeden asks whether the HOSF maximum reimbursement is always full charges. She also asks the Commission to define "scheduled" surgical services. She states that the HOSF CPT code range 10021-69990 should be adjusted to exclude codes 36415 and 36416 because they are blood draw charges which often accompany other lab charges and they are not true surgical procedures.

Agency Analysis: The Commission changed the language the HOSF, Section 7110.90(h)((7)(D)(i), from "maximum reimbursement" to "maximum fee schedule amount" to clarify that the fee schedule amount may not be the amount paid if the actual charge is less than the fee schedule. The Commission deleted the word "scheduled" from both Section 7D of the Instructions and Guidelines and Section 7110.90(h)(7)(F)(i) of the rules. Codes 36415 and 36416 are not included in the HOSF fee schedule.

i) Ms. Breeden states that the payment guides relating to global days, assistant surgeons, co-surgeons, and team surgery do not apply to HOSF billing.

Agency Analysis: The Commission agrees and deleted the payments guides that relate to global days, assistant surgeons, co-surgeons, and team surgery from Section 7110.90(h)(7)(F)(iii) of the rules and Section 7 of the instructions and guidelines.

j) Ms. Breeden states that modifier 51(multiple procedures) is appropriate for a physician but not a HOSF. She suggests that Section 7D of the instructions and guidelines indicate that when multiple procedures are performed, payment will be made at 100% of the highest fee schedule amount and then at 50% of the next four highest fee schedule amounts.

Agency Analysis: It is the Commission's position that Modifier 51 is appropriate in a hospital outpatient surgical facility setting. It is standard practice to apply the modifier in this area and the schedule was designed to accommodate the modifier. Section 8F of the instructions and guidelines is clear regarding Modifier 51. The payer pays the lesser of the actual charge or 100% of the fee schedule amount for the procedure with the highest payment, and the lesser of 50% of actual charge or 50% of the fee schedule amount for the second through fifth procedures. All procedures thereafter are priced on a "by report" basis as determined by the payer and provider.

k) Ms. Breeden states that the Section 8(B) bilateral surgery modifier 50 applies to the HOSF billing but, when applying both 8(B) and 8(F), reimbursement would be at 150% of the fee schedule. She states that it is confusing when a bilateral procedure is performed in conjunction with a procedure on the fee schedule that has a higher reimbursement level. She states that when

modifier 50 is reported, the bilateral procedure should be counted twice, and reimbursement should follow the multiple procedure reimbursement methodology.

Agency Analysis: When a bilateral procedure is performed in conjunction with other multiple procedures and the bilateral procedure is the highest cost procedure, it is billed as one unit and reimbursed at 150% with the lower cost procedures paid at the lesser of 50% of actual charge or 50% of the fee schedule. If the bilateral procedure is not the highest cost procedure, the highest cost procedure is reimbursed at the lesser of 100% of the actual charge or 100% of the fee schedule amount and the lower cost bilateral procedure at 50% of 150% of the fee or 75%. This reimbursement method is consistent with CMS reimbursement methodology and policies. The Commission has added examples of reimbursement to the instructions and guidelines to clarify the payment application when a bilateral procedure is performed in conjunction with multiple procedures.

l) Ms. Breeden asks if Section 7D of the instructions and guidelines provides that the entire claim reverts to 76% of charge when multiple procedures are payable under the schedule and others at 76% of charge. She states that the "lesser of" language needs to be addressed in this section and defined as the total adjusted charge level rather than at the individual charge/CPT level.

Agency Analysis: Under Section 8(a) of the Act and Section 7110.90(e) of the rules, whenever the fee schedule does not set a fee for a procedure, reimbursement is at 76% of charge except where revenue codes are to be deducted from the charge and reimbursed at 65% of charge. Under the HOSF schedule, if a surgical procedure is not found in the schedule all charges are to be paid at 76% of charge subject to the 65% pass through revenue code categories. The HOSF schedule provides for a global reimbursement and is concerned with total charges on the bill, not with individual line item amounts. The HOSF fee schedule calculation combines amounts for all services performed in a single operative setting. Therefore, it is impossible to calculate a global fee for procedures not found in the schedule. In this situation the entire bill, minus carve-outs or other exceptions, defaults to 76% of charge. Regarding the "lesser of" language, both Section 7D of the instructions and guidelines and Section 7110.90(h)(7)(F)(i) of the rules have been clarified to provide that the fee schedule provides the global maximum "fee schedule amount" rather than global maximum "reimbursement." The Commission also added the following language to Section 7110.90(h)(7)(F)(i) to define a single fee schedule amount and make it clear that the fee schedule is not to be applied on a line item basis: "The single fee schedule amount shall represent the maximum amount payable for the total charges on a claim form which represents the total charges derived from all line items/revenue codes contained therein. Except for the carve-out revenue codes listed below, this fee schedule shall not be applied on a line item basis."

m) Ms. Breeden suggests adding language to Section 8 (professional schedule) of the instructions and guidelines indicating that hospital professional fees billed by a hospital using the hospital tax ID number are paid at 76% of charge and hospital professional fees billed using the physician's tax ID number are paid under the professional services fee schedule.

Agency Analysis: Similar language already appears in the hospital inpatient schedule (Section 7110.90(h)(6)(H)) and the hospital outpatient schedule (Section 7110.90(h)(7)(F)(vi)). It is not necessary to add the language to the professional fee schedule as this schedule does not apply to hospitals.

3) Ann Bresnen (Director of Business Development, Midwest Orthopaedic Network)

a) Ms. Bresnen states that it was her understanding that the IME (independent medical examination) CPT code (99456) was to be removed from the professional fee schedule. She states that the instructions and guidelines provide that the IME should be paid at usual and customary which leaves the payment decision to the payer. She states that physicians feel strongly that the IME charge should be as negotiated by the physician and payer and asks that the usual and customary language be removed.

Agency Analysis: The instructions and guidelines did indicate that Miscellaneous Services codes 99024-99091 would be removed because the historical charge data was extremely variable; that the non-treating physician exam code 99456 would be removed because it was mistakenly included in the schedule; and that these removed codes would be payable at the usual and customary rate. The Commission, however, does not now believe that code 99456 should be removed because the code applies to more than independent medical examinations (i.e., second opinion or treatment guidelines requested by a family physician). The Commission is aware that when doctors perform a Section 12 examination, commonly referred to as an IME, they often submit their charges with CPT code of 99456 found in the professional fee schedule which causes payers to pay the fee schedule rate rather than the negotiated rate. In order to provide clarification in the instructions and guidelines, the Commission will delete the reference to removing code 99456 and provide that when a provider is billing for an IME at the request of the payer/employer, the fee schedule does not apply and the bill will be paid at the agreed upon negotiated rate. The language regarding usual and customary will apply only to codes 99024 to 99091.

b) Ms. Bresnen also requests that G-codes be removed.

Agency Analysis: G-codes (temporary codes in the HCPCS fee schedule for which there are no current CPT codes) cover less than 1% of workers' compensation treatment. They are eventually eliminated or become permanent CPT codes payable at 76% of charge. No concerns or issues have been raised over the codes to date. Since G-codes are already in the schedule and are rarely used in workers' compensation treatment, there is no reason to remove them at this time.

4) Elena Butkus (Vice President, Finance, Illinois Hospital Association (IHA))

a) Ms. Butkus proposes that language be added to Section 7110.90(d) and Section 710.90(h)(7)(F)(i) to clarify the maximum allowable payment (lesser of actual charge or the fee schedule unless there is a contract between the payer and provider in which case the negotiated rate shall prevail.) She states that language should be added to state that the lesser of methodology applies to the total charges on the hospital outpatient procedures and not to line items on the bill. Ms. Butkus also indicates that the term "global" in Section 7110.90(h)(7)(F)(i) implies the payer need only pay the CPT code and leave associated revenue codes unpaid.

Agency Analysis: The Commission believes Section 7110.90(d) clearly sets forth that the employer pays the lesser of actual charge or the fee schedule rate unless there is a contract in which case the contractual rate prevails. The Commission changed Section 7110.90(h)(7)(F)(i) to indicate that the schedule is the "global maximum fee schedule amount" rather than the "global maximum reimbursement." The Commission also added the following language to Section 7110.90(h)(7)(F)(i) to define a single fee schedule amount and make it clear that the fee

schedule is not to be applied on a line item basis: "The single fee schedule amount shall represent the maximum amount payable for the total charges on a claim form which represents the total charges derived from all line items/revenue codes contained therein. Except for the carve-out revenue codes listed below, this fee schedule shall not be applied on a line item basis."

b) Ms. Butkus proposes that the language in the hospital inpatient, Section 7110.909(h)(6)(A), be clarified to indicate that the DRG or MS-DRG is the maximum fee schedule amount rather that the maximum reimbursement. She also suggests that the hospital outpatient surgical facility fee schedule be changed (Sections 7110.90(h)(7)(C)(i), radiology, 7110.90(h)(7)(D)(i), pathology and laboratory, 7110.90(h)(7)(E)(i), and physical medicine and rehabilitation), to clarify that the fee schedules list the maximum fee schedule amount and not the maximum payment amount.

Agency Analysis: The Commission changed Sections 7110.90(h)(6)(A) and 7110.90(h)(6)(B) of the hospital inpatient schedule to provide that the DRG and MS-DRG are the "maximum fee schedule amount" instead of the "maximum amount of payment." The Commission changed Section 7110.90(h)(7)(C)(i), radiology, Section 7110.90(h)(7)(D)(i), pathology and laboratory, and Section 7110.90(h)(7)(E)(i), physical medicine and rehabilitation, to clarify that the fee schedules are the "maximum fee schedule amount" instead of "one level of maximum reimbursement."

c) Ms. Butkus proposes that the phrase "no later dates or editions" be deleted from Section 7110.90(H)(6)(B) to allow the Commission to always use the most current MS-DRG system that is updated by Medicare on October lst. She stated that is not administratively feasible for providers to run dual systems (both old and new versions).

Agency Analysis: Section 5-75 of the Illinois Administrative Procedure Act (5 ILCS 100/5-75) requires that when a regulation is incorporated by reference into a rule, the rule must identify the incorporated matter by publisher address and date and state that no later amendments or editions are included. The rules of the Secretary of State also require that a rule that includes an incorporation by reference must state that no later editions or amendments are included.

d) Ms. Butkus states that, for consistency, the language proposed in Section 7110.90(h)(7)(F)(vi) relating to charges for professional services performed in conjunction with other services be added to the hospital inpatient and professional services schedules.

Agency Analysis: The Commission added to Section 7100.90(h)(6)(H) of the hospital inpatient schedule language almost identical to that found in Section 7110.90(h)(7)(F)(vi). The Commission does not believe that the section should be added to the professional services schedule as the language relates only to billing in hospitals.

e) Ms. Butkus states that in Section 7110.90(h)(7)(B), the term “scheduled” as it applies to surgical services must be clarified as the term is not used in the provider community. She states that the units billed for the radiology, pathology and laboratory, and physical medicine and rehabilitation fee schedules must be recognized.

Agency Analysis: In Section 7110.90(h)(7)(B), the Commission deleted the word "scheduled" and clarified surgical services as services performed in a hospital outpatient setting "that were not performed during an emergency room encounter or inpatient hospital admission." The Commission also changed Section 7110.90(h)(7)(B) to provide that "The radiology, pathology and laboratory, and physical medicine and rehabilitation fee schedules shall be applied to the number of units billed on the UB-04."

f) Ms. Butkus proposes deleting the payment guides in Section 7110.90(h)(7)(F)(iii), with the exception of multiple procedures and bilateral surgeries, because they do not apply to a hospital outpatient setting. She states that the statute does not recognize multiple-procedure discounts and the IHA disagrees with their application. Ms. Butkus states that if the Commission does not agree with IHA's position, language should be added to indicate that outpatient multiple surgical procedures shall be reimbursed at 100% for the procedure with the highest fee and 50% for each additional procedure. She states that bilateral procedures billed under Modifier 50 should be recognized as two distinct procedures and reimbursed accordingly at 100% for each procedure.

Agency Analysis: The Commission believes that the principles in all of the payment guides are universally accepted and permitted by the statute. However, the Commission recognizes that only multiple procedures and bilateral surgeries apply to the HOSF. The Commission deleted references to global days, assistant surgeons, co-surgeons and team surgery from Section 7110.90(h)(7)(F)(iii). Sections 8B and 8F of the instructions and guidelines provide that when bilateral procedures are performed with other multiple procedures, the bilateral procedure is billed as one unit. If the bilateral procedure is the highest cost procedure, it is paid at 150% with the lower cost procedures paid at 50%. If the bilateral procedure is not the highest cost procedure, it is reimbursed at 50% of 150% of the fee or 75%.

g) Ms. Butkus states that the IHA believes that the hospital outpatient surgical service outlier language is consistent with the current marketplace and it is imperative the language referenced in the current rule and guidelines remain intact for high cost/high utilization services.

Agency Analysis: The Commission agrees with the IHA's position on the cost outlier. The Commission did clarify the cost outlier by providing that outlier status is reach when the bill for hospital outpatient facility surgical charges is "at least two times the fee schedule amount" instead of "equal to or two times the fee schedule amount."

h) Ms. Butkus states that changes to the rules should be applied to the instructions and guidelines. She states that the Commission should include billing examples of how claims should be paid and FAQs in the instructions and guidelines.

Agency Analysis: Any changes to the rules will also be incorporated in the instructions and guidelines. The Commission already includes FAQs on its medical fee schedule website and has added examples of billing to the instructions and guidelines.

i) Ms. Butkus indicates that the IHA thanks IWCC for addressing the issue of freestanding rehabilitation hospitals and for computing per diems. She states that the IHA previously requested that IWCC evaluate payment to these institutions that take care of some of the worst trauma injuries by removing them from the fee schedule.

Agency Analysis: Section 8.2 of the Act provides for a hospital inpatient schedule but does not exempt specific hospitals. The Commission has worked with interested parties since the initial adoption of the fee schedule in 2006 to identify a solution regarding freestanding rehabilitation hospitals. The Commission believes the fee schedule provides a system of reimbursement for the hospitals which takes into account the issues that are unique to a freestanding rehabilitation hospital.

5) Anne Cole (Administrator, Ingalls Same Day Surgery Center)

Ms. Cole requests that the ambulatory surgical treatment center (ASTC) fee schedule not be limited to the 5 codes set forth in the proposed rules because the codes do not include all charges for the supplies and time necessary for repair when multiple procedures are performed. She asks that the Commission consider all the CPT codes that would be considered with a billing.

Agency Analysis: The limitation of 5 CPT codes is standard. If more than five procedures are performed, these are usually addressed "by report" (where there is no fee schedule amount and payment is determined by the payer and provider.) The limitation of 5 codes also has cost containment features as it encourages providers to practice careful coding and discourages billing for unnecessary procedures.

6) Mark Mayo (Director, Ambulatory Surgery Center Association of Illinois)

Mr. Mayo stated that he wanted to go on the record to thank the Commission for reviewing the rate methodology and catching up to the substantial changes that have been made in the ambulatory surgery center payment mechanism through the federal government (CMS). He indicated that the changes have allowed surgery centers and hospitals to be priced on a parity basis and to use the same methodology for case coding.

Agency Analysis: The Commission believes that the cost associated with procedures performed in an ASTC setting is less than those performed in a hospital setting. The ASTC fee schedule reimbursement rates reflect the lower costs of an ASTC.

7) Barbara Molloy (President, Molloy Consulting Incorporated)

a) Ms. Molloy states that the Commission should remove procedures that are now in the ASTC fee schedule that CMS has found cannot be safely performed in an ASTC. She states that the ASTC schedule over reimburses for procedures that are typically performed in a physician's office because CMS pays less for these procedures than the ASTC schedule. She recommends that the procedures be removed from the ASTC schedule or be reimbursed at the lower of supply costs or 25% of the ASTC fees.

Agency Analysis: The Commission adopted the coding architecture from CMS, but not necessarily every rule associated with the codes. CMS does have some restrictions as to procedures that should not be performed in an outpatient surgical setting that are more restrictive than what is actually practiced. The schedule simply provides fee schedule levels for procedures that could and will be performed in an outpatient setting. The Commission does not take the position that the fee schedule should be used as a treatment guideline or instruction as to where to perform a procedure. Physician services performed in an ASTC are not over-reimbursed because the ASTC setting is more expensive than a physician's office and the ASTC facility fees reflect the higher cost. Only those facilities that meet the definition of an ASTC will be reimbursed under the ASTC schedule. Properly submitted bills will result in fair and reasonable payment, not substantial overpayment.

b) Ms. Molloy states that the proposed rules provide for an outlier for the hospital outpatient schedule but not the ASTC schedule even though the services are similar. She states that a hospital outpatient outlier may be appropriate where a hospital uses resources beyond the

capability of the ASTC. She states that a hospital outlier payment for procedures CMS finds eligible for payment in an ASTC setting rewards high charging hospitals. She recommends limiting outlier payments to procedures CMS requires in a hospital setting, and where on the day of the procedures the patient's stay extends beyond 11:59 p.m. or the patient expires. She states that there is no basis for extraordinary care if the patient was safely discharged prior to 11:59 p.m. on the day of the procedure.

Agency Analysis: IWCC utilized the same outlier formula that was utilized for the DRG hospital inpatient fee schedule. The more complex and difficult outpatient surgeries are performed in a hospital setting where there is a greater potential for an outlier case. CMS and other payers apply an outlier to a hospital outpatient setting but not to an ASTC. The IHA agrees with the hospital outpatient outlier provision and has indicated that an outlier provision is not appropriate for an ASTC. The Commission believes the cost threshold outlier is the most practical, and that the suggested limitations to the outlier provision are too narrow. There is no evidence that hospitals are inflating charges to reach the outlier.

c) Ms. Molloy states that the proposed instructions and guidelines should include Modifier 73 (discontinued outpatient procedure prior to anesthesia administration) and Modifier 74 (discontinued outpatient procedure after anesthesia administration). She recommends that to reflect the lower cost in such circumstances, the reimbursement level for Modifier 73 should be the same as CMS which reduces payment by 50% for both the ASTC and hospital outpatient setting. Ms. Molloy states that that the Commission's reimbursement of Modifier 52 (reduced services) at the lesser of charge or 76% of the fee schedule is too high. She recommends that the Commission follow the CMS 50% reimbursement reduction of Modifier 52 to reflect the considerable resource savings to the facility.

Agency Analysis: The Commission will include Modifiers 73 and 74 in the instructions and guidelines. Modifiers 73 and 74 are approved for ASTC and hospital outpatient use. These discontinued procedures reflect substantially reduced facility fees. Modifiers 73 and 74 are similar to Modifiers 52 (reduced services) and 53 (discontinued procedure) that apply to the professional services fee schedule. Modifiers 52 and 53 are paid at the lesser of charge or 76% of the fee schedule amount. Similarly, reimbursement for Modifiers 73 and 74 will also be at the lesser of charge or 76% of the fee schedule. Section 8.2 of the Act was not intended to create a CMS Medicare fee schedule. While the schedule includes some Medicare concepts, it does not adopt Medicare rates.

d) Ms. Molloy states that the proposed single fee schedule for physical medicine is not consistent with the associated revenue codes and how services in physical medicine are reported. She states that in hospital billing, revenue codes are the most encompassing codes and can be paired with a procedure code. She indicates that in physical, occupational and speech therapy, certain revenue codes include a time dimension and fees will be overstated if revenue codes with different time dimensions are mixed. She states that when the single fee schedule amounts for physical medicine were developed, if an adjustment was not made to take into account the varying time units, the schedule over-compensates hospitals for physical medicine services.

Agency Analysis: For practical purposes, IWCC established a single fee schedule level for the physical medicine portion of the hospital outpatient fee schedule. While adjustments may be made in other settings, the vast majority of cases in the workers' compensation setting are going to relate to a single unit of care for an individual patient in a typical physical therapy setting. Additionally, attempting to differentiate payment for these codes based on revenue codes would be difficult and there is no need to get this specific in the area of workers compensation. The

schedule properly addresses 99% of cases and there is no need to introduce this level of complexity into the schedule. The fee schedule is based on historical data, which resulted in some anomalies. Section 8.2 does not provide a remedy to address the anomalous outcomes. Section 8.2 allows only inflationary adjustments if there is a significant limitation on access to quality health care in a specific field or geographical area. These adjustments can make only incremental changes.

Research was conducted that limited the revenue codes to those designed to elicit CPT-descriptive unit and time values. The research showed that basically everything remained the same despite the narrowing of the database characteristics and removal of the revenue codes that could import specific time increments. The unit values included in the data are intended to reflect CPT descriptors. When revenue codes that might impact CPT descriptors were removed from the data mix, a similar small number of anomalies of a similar nature occurred. The Commission does not agree that the entire schedule should be eliminated because of the anomalies. While some of the anomalies resulted in high reimbursement rates, others resulted in low reimbursement rates. The Commission will work with all interested parties in finding a solution to both the high and low reimbursement rates but believes that the schedule will result in costs savings and should go forward at this time. Furthermore, the majority of physical therapy services are performed in a non-hospital setting and are reimbursed under the professional services fee schedule.

e) Ms. Molloy states that reimbursement in the proposed hospital outpatient fee schedule is inconsistent because some fees are significantly more than the professional schedule and others significantly less. She states that no consistent relationship exists for the radiology, pathology, laboratory and physical medicine services in non-hospital and hospital settings among geozips. Ms. Molloy states that when the legislation was proposed, employers were concerned that providers charging less than the schedule would increase their prices to the fee schedule amount. She states that the schedule has created a price spike and that floor and ceiling prices are now relatively indistinguishable. Ms. Molloy states additional time is needed to consider alternative methodologies to develop the values of the hospital outpatient schedule.

Agency Analysis: The Commission established the hospital outpatient schedule in accordance with Section 8.2 of the Act. Section 8.2 requires that the reimbursement rates are to be based on historical charge data from 2002 to 2004, but does not require consistent relationships among geozips. The Commission believes that the methodology set forth in Section 8.2 resulted in some anomalies, which can be expected. Section 8.2 does not provide a remedy to address the anomalous outcomes, with the exception of the inflationary adjustment, which can make only incremental changes. The Commission is authorized to use only the methodology set forth in Section 8.2 of the Act. The Commission has been working with interested parties for over two years to establish the schedule.

f) Ms. Molloy states that the number of codes paid at 76% of charge will continue to increase and the Commission can price new codes by comparing the CMS relative value for each new code to codes of similar relative value in the same medical specialty. She states that renumbered codes can be priced the same as the old code. She states that this is consistent with the statutory intent as it minimizes the number of codes paid at 76% of charge.

Agency Analysis: Section 8.2 does not provide the authority to use relative values as a basis for establishing fee schedule amounts for new CPT codes. Section 8.2 provides that if there is no data or insufficient data from 2002 to 2004 for a code, the reimbursement rate defaults to 76% of charge. The statute does not provide any other method for establishing a reimbursement rate for

codes without sufficient historical data, including new codes for which no data from 2002 to 2004 exists.

g) Ms. Molloy states that there is concern that the rules are subject to interpretation and require complex specific, per claim analysis to determine payment. She states that the zip code schedules are inconsistent schedules and do not represent best practices as regards fee schedule construction. She states that Medicare has 4 schedules for Illinois; BCBS (largest insurer in the state) has 2; the IWCC has 29.

Agency Analysis: The area of hospital outpatient surgical facility billing is a difficult area of medical billing and requires more challenging rules. However, the rules and fee schedule introduce a more global concept of reimbursement which is easier to administer than other systems such Ambulatory Payment Classification (APC) methodology. Illinois has 29 fee schedules because Section 8.2 of the Act requires that the schedules be established by geozip (three digit zip code based on data similarities geographical similarities, and frequencies).

h) Ms. Molloy states that estimated cost savings have not materialized, and that the newly proposed schedules, if adopted unadjusted, will further increase costs for employers.

Agency Analysis: The Commission developed all of the fee schedules as mandated by Section 8.2 of the Act. Section 8.2 does not provide a methodology to adjust the schedules based on cost savings expectations. The proposed ambulatory surgical treatment center and hospital outpatient fee schedules were developed at the request of the business community to address the gaps in the initial fee schedule. It is anticipated that there will be savings to employers because reimbursement rates with annual increases held to the Consumer Price Index-U have now been established for a broad area of treatment which was previously paid at 76% of charge with no cap on increasing costs.

8) Marti Panikkar (RN, CPUR, Medical Review Specialist, Risk Management Department, Arkansas Best Corporation)

a) Ms. Panikkar disagrees with the proposed provisions relating to professional charges such as CRNA and emergency department physicians in Sections 4, 7D and cost outliers in Section 7E in the Instructions and Guidelines. Ms. Panikkar states that hospitals bill hugely inflated fees for CRNA and ER professional services and it is unfair that these professionals receive payment different from other professionals who choose to bill independently. She states that these professionals should be subject to the professional services fee schedule and the same reimbursement should be due to anyone who renders the same service.

Agency Analysis: The Commission has no evidence that hospitals inflate these fees. Additionally, it was decided at the time of the fee schedule development that services provided in the hospital setting should be separated from services provided in a professional setting. The Commission has consistently kept the professional services fee schedule from being applied to hospitals.

b) Ms. Panikkar asks that the cost outlier be removed from the hospital outpatient fee schedule (HOSF) because there should not be unusually high costs. She states that an allowance for such costs has already been made by addressing expensive implants. She states that hospitals bill exorbitant amounts for revenue codes that require no support of charges (anesthesia and room charges) and outlier status can be met by increasing rates without any requirement that the case is

one for which the costs are unusually high. She requests that at the very least the calculation should subtract double the fee schedule allowance before applying 76% of charge.

Agency Analysis: While hospital costs can be high, there is no evidence that hospitals will intentionally and fraudulently manipulate their fees to maximize fee schedule reimbursement. There is no evidence that complications do not arise in a hospital outpatient setting. The cost outlier provision is simply designed to ensure adequate reimbursement in those cases where complications and extraordinary treatment are required. The proposed definition, which is identical to the hospital inpatient outlier definition adopted in 2006, sets a high threshold intended to capture cases involving extraordinary treatment and is supported by the Illinois Hospital Association

9) Jay Shattuck (Illinois Chamber Employment Law Council)

a) Mr. Shattuck states that he appreciates the Commission's efforts on finding the appropriate database for the hospital outpatient schedule. He states that the Illinois State Chamber has wanted the hospital outpatient schedule since February of 2006 and is glad we will be moving from 76% of charge to fee schedule rates which will help save employers dollars in the future. He states that there is a concern that the database may have been flawed because there may have been unit charges that may not have been part of the calculation in determining the reimbursement rate per CPT code. He states that he would like more time to do some additional analysis to see if concerns are justified.

Agency Analysis: The fee schedule is based on historical data which resulted in some anomalies. Section 8.2 does not provide a remedy to address the anomalous outcomes. Section 8.2 allows only inflationary adjustments if there is a significant limitation on access to quality health care in a specific field or geographical area. These adjustments can make only incremental changes. Research was conducted that limited the revenue codes to those designed to elicit CPT-descriptive unit and time values. The research showed that basically everything remained the same despite the narrowing of the database characteristics and removal of the revenue codes that could impact specific time increments. The unit values included in the data are intended to reflect CPT descriptors. When revenue codes that might impact CPT descriptors were removed from the data mix, a similar small number of anomalies of a similar nature occurred. The Commission does not agree that the entire schedule should be eliminated because of the anomalies, some of which resulted in high reimbursement rates, some in low reimbursement rates. The schedule properly addresses 99% of the cases. The Commission will work with all interested parties in finding a solution to the anomalous outcomes but believes that the schedule will result in cost savings.

b) Mr. Shattuck states that there are concerns regarding inpatient pass-through charges regarding implants. He states that he believes there are abuses of the 65% of charge reimbursement rate. Mr. Shattuck states that other states are more transparent in their charges in that a copy of the amount paid by the facility for the implant is presented to the payer with a markup of that amount from 0 to 50%.

Agency Analysis: The reimbursement of pass-through charges at 65% was extensively debated before it was adopted in 2006. The purpose of setting pass-through charges at 65% of charge was cost containment and to allow for new and improved technologies to be utilized which did not exist or have been improved since the period of historical charge data (August 1, 2002 through August 1, 2004). The reimbursement rate represents a significant improvement for

payers. Providers who deviate from their standard charge master amounts should be scrutinized by payers.

c) Mr. Shattuck states that the hospital outpatient radiology and pathology billing professional reimbursement rate of 76% of charge (as opposed to the fee schedule amount) if you are billing with hospital identifier ID may be subject to abuse. He indicates that if the 76% rate is desired it would be easy to use the hospital identifier to get the 76% rate as opposed to the fee schedule rate.

Agency Analysis: There is no evidence that professionals have billed under the hospital's tax identification number in order to be reimbursed at 76% of charge. The Commission believes the scenario of medical professionals billing in this manner just for monetary gain to be highly unlikely.

d) Mr. Shattuck states that cost outliers in the hospital inpatient and outpatient schedules define extraordinary treatment as 200% of the fee schedule charge. He states that extraordinary treatment should be defined by type of injury rather than the amount charged. Mr. Shattuck states that the rehabilitation hospital reimbursement schedule approach will address some of those types of cases and injuries and is a move in the right direction.

Agency Analysis: Section 8.2(c) of the Act requires the Commission to establish a process to review medical cases or outliers that involve extraordinary treatment to determine whether to adjust the maximum payment in the fee schedule. Section 8.2 does not require that the Commission base outlier status on type of injury. The definition for the hospital outpatient surgical facility outlier is similar to the hospital inpatient definition which was debated and adopted in 2006. The definition is supported by the Illinois Hospital Association and the Commission has relied on precedent set by CMS and private health care plans which determine outliers based on a fixed cost threshold. The definition sets a high threshold intended to capture cases involving extraordinary treatment as required by Section 8.2 of the Act.